Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN119AGC	A. BUILDING _____ B. WING _____	C 08/13/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HILLS RESIDENTIAL GROUP CARE 1	8115 MOHAWK LN RENO, NV 89506

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a complaint investigation conducted between 7/16/10 and 8/13/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for seven Residential Facility for Group beds for elderly and disabled persons, Category I residents. The census at the time of the survey was seven. Three resident files were reviewed and one employee files were reviewed. Complaint #NV00025908 was substantiated. See Tag Y592.	Y 000		
Y 592 SS=H	449.268(1)(c) Resident Rights NAC 449.268 1. The administrator of a residential facility shall ensure that: (c) The residents are treated with respect and dignity. This Regulation is not met as evidenced by: Based on observations, record review and interviews conducted between 7/16/10 and 8/13/10, the administrator failed to ensure that 2	Y 592		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 592	Continued From page 1 of 4 female residents were treated with dignity and respect by a male member of the staff (Employee #2). Findings include: Resident #4 was a 49 year old female with a long-standing medical history of severe depression and a prior suicide attempt wherein she consumed over 100 Paxil tablets with alcohol, leading to cardiac arrest and permanent damage to her brain and central nervous system. The resident had been unable to live independently since that event, requiring assistance with activities of daily living including personal care, bathing, toileting, meal preparation and laundry. The resident demonstrated difficulty with speech and used a walker to ambulate. Resident #4 was admitted to a psychiatric hospital on 7/16/10 after telling her guardian that she was going to "lie on the railroad tracks and wait for a train to arrive." The resident was interviewed at the hospital on several occasions by the police and a bureau employee during the course of the complaint investigation. During these interviews, the resident demonstrated a high level of anxiety and emotional distress, including uncontrolled episodes of crying. The resident also revealed that she had been having a sexual relationship with one of her male caregivers. Resident #4 stated Employee #2 would buy special treats for her such as candy, pizza and cigarettes and would provide her with extra attention in an attempt to "groom her in the manner a predator would use to break down the resistance of a potential victim." The resident reported she and the male employee would	Y 592		

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Y 592	Continued From page 2 engage in sexual activities twice a week during bathing times and that she was a willing participant. Employee #2 was a 50 year old male caregiver employed by the facility. Employee #2 was married, but his wife and children were living outside of the country. Employee #2 was responsible for assisting Resident #4 with personal grooming and bathing. The employee admitted bringing the resident special treats in an effort to gain her trust. The employee also admitted that he and the resident engaged in consensual sex from February 2010 to July 2010. Resident #7 was a 49 year old female with diagnoses of Huntington's disease, diabetes and dementia. Huntington's disease is a progressive neurodegenerative disorder which affects muscle coordination and leads to cognitive decline and dementia. Resident #7 demonstrated difficulty with ambulation and communication. The resident stated that Employee #2 kissed her on the mouth and touched her breasts on a daily basis for the past several months. The employee denied kissing or touching this resident. Employee #2 failed to treat two female residents with dignity and respect by engaging in inappropriate sexual behaviors with individuals suffering from disabling conditions. Severity: 3 Scope: 2	Y 592		